

# **TEXAS EYE INSTITUTE**

## **REFRACTION POLICY**

The Center of Medicare and Medicaid Services (CMS) utilizes the Resource Based Relative Value Scale (RBRVS) to determine the fees for all Medicare providers. Most of the other insurance companies use this same system to set their payment schedules.

During your visit refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam, and in many cases, it is the sole reason for the appointment.

Please be aware that this is a NON-COVERED service by Medicare and most insurance companies and is the responsibility of the patient. Our Office currently charges \$35.00 as a discounted cash price for this procedure, which is less than the RBRVS suggested rate.

We appreciate your cooperation in collecting this fee at the time of service.

I have read the above information and understand I may be charged a cash discounted price of \$35.00 at the time of service. If billing is required, the full charge will be billed.

## **CONTACT LENS POLICY**

The Glasses prescription you receive from Texas Eye Institute is not a contact lens prescription. A qualified optician must fit contact lenses. Texas Optics Institute or an optical shop of your choice may fit the contact lenses for a separate fee. After your contact lens fitting is completed, it is your right to receive a copy of your contact lens specification from the optical shop selected if you desire.

I have read and understand the above refraction and contact lens policy.

## **APPOINTMENT REMINDER POLICY**

Texas Eye Institute utilizes an Appointment Call Center to contact you by telephone at the phone number provided to remind you of future appointments and other matters associated with your overall healthcare component. Message will be left by the Automated Call Center on your answering machine and/or voice mail service.

I CONSENT    DO NOT CONSENT    to being notified by the Automated Call Center.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date